The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 2 (Queensland)

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PART I: INTRODUCTION

The intention of this series of articles is to examine the legal frameworks in three Australian jurisdictions that are applicable to decisions concerning the withholding or withdrawing of life-sustaining treatment from adults who lack capacity. This article is the second of three articles in the series and examines the law in Queensland. As with the first article, the main focus of the discussion is how the legal framework applies to medical professionals who are faced with a scenario concerning the withholding or withdrawing of life-sustaining medical treatment.

The structure of this article is similar to that adopted in the other articles in this series. Part II will consider the legal framework in place within Queensland, and will apply it to the different medical contexts that were identified in the first paper (and which are briefly recapped below). Part II then explores in some depth the scope of the *parens patriae* jurisdiction of the Supreme Court. Although this topic was considered in the first article, this article will explore aspects of that jurisdiction in more detail. Finally, Part II identifies the problems associated with the law in Queensland as they relate to conclusions made about medical professionals' knowledge of the law. Part III of the article reviews what medical professionals are taught about the law in this area, and of any literature that sheds light on the extent of the legal knowledge of medical professionals. Part IV concludes with a consideration of aspects of Queensland law that may need reform.

PART II: THE LAW IN QUEENSLAND

1. Medical context and legal decision-making mechanisms

In this part of the article, the Queensland law that governs withholding and withdrawing medical treatment from adults who lack decision-making capacity in various medical contexts will be explored. As explained in the first article, there are three different *medical contexts* in which a decision may need to be made about withholding or withdrawing treatment. The first is where the medical professional would consider it medically appropriate to offer life-sustaining treatment. The second is where the medical professional regards life-sustaining treatment to be futile. The third is where an urgent decision about whether or not to provide life-sustaining treatment is required.

As in the first article, the various *legal decision-making mechanisms* will be considered in each of these medical contexts. These mechanisms include where an adult has completed an

advance directive or has appointed an attorney under an enduring power of attorney, where the Queensland Civil and Administrative Tribunal (QCAT) has appointed a guardian, or where there is a default decision-maker.

Again, particular consideration is given to the role that is played by the medical professional in each medical context, and under the various legal decision-making mechanisms. Both the guardianship legislation and the common law will be considered.

2. Guardianship Law in Queensland

2.1 The legal framework – an overview

In Queensland, the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld) govern the withholding and withdrawal of life-sustaining medical treatment from adults who lack decision-making capacity. For the purpose of this article, these statutes are collectively referred to as the 'guardianship legislation'. It should be noted that this legislation is currently being reviewed by the Queensland Law Reform Commission. One of the Working Papers published by the Commission as part of its review has raised a number of issues that relate to the law that is considered in this article.[1] At the time of writing, the final report of the Commission has not been published.

Pursuant to the guardianship legislation, life-sustaining medical treatment can be withheld or withdrawn from a person who lacks capacity. This can occur through various legal means. Such a decision can be made by the adult through an advance health directive that is completed before losing capacity or, in the absence of such a directive, by a substitute decision-maker who has power to make decisions about 'health care'. A substitute decision-maker can be a guardian appointed by QCAT, an attorney appointed by the adult under an enduring power of attorney, or a 'statutory health attorney' who is a default decision-maker prescribed by the legislation. QCAT itself also has power to make a decision about withholding or withdrawing treatment.

The legislation defines 'health care' to include:

> …withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.[2]

A 'life-sustaining measure' is defined in the following terms:

> (1) A life-sustaining measure is health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation.
> (2) Without limiting subsection (1), each of the following is a life-sustaining measure—

[1] Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper No 68 (2009) vol 1, chs 11 and 12.
[2] *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(2). An equivalent, though not identical, definition exists in the *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2).

(a) cardiopulmonary resuscitation;
(b) assisted ventilation;
(c) artificial nutrition and hydration.

(3) A blood transfusion is not a life-sustaining measure.[3]

The decision-making regime therefore expressly contemplates decision-making about withholding or withdrawing treatment necessary to keep a person alive.

2.2 Capacity

Before a medical professional can seek a decision about medical treatment from someone other than the adult, he or she must be satisfied that the adult lacks capacity to make the decision. Under the Queensland legislation, a person has capacity to make a decision about health care if he or she is capable of:

(a) understanding the nature and effect of decisions about the matter;
(b) freely and voluntarily making decisions about the matter; and
(c) communicating the decision in some way.[4]

Under the Queensland legislation, an adult is presumed to have capacity to make decisions about medical treatment.[5]

Role of medical professional

As a starting point, it is therefore necessary that the medical professional has an understanding of the legislative definition of capacity in order to establish whether the adult lacks capacity. The professional should further realise that there is a presumption that all adults have capacity to make decisions about treatment, and that he or she will need to have evidence that this presumption is rebutted before the statutory regime is activated.

2.3 Category 1 – medical professional considers offering life-sustaining treatment to be medically appropriate

The next section of Part II will consider the Queensland laws that apply where a medical professional is faced with a decision concerning the withholding or withdrawal of a life-sustaining measure. The three medical contexts outlined above will be considered. The first category of case arises where the medical professional considers that it is medically appropriate to offer medical treatment for the adult who lacks decision-making capacity. The law that governs the situation will depend on the particular decision-making mechanism that applies.

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[3] *Guardianship and Administration Act 2000* (Qld) sch 2 s 5A and *Powers of Attorney Act 1998* (Qld) sch 2 s 5A.

[4] *Guardianship and Administration Act 2000* (Qld) sch 4 and *Powers of Attorney Act 1998* (Qld) sch 3. Note that the *Powers of Attorney Act 1998* (Qld) has an additional test for capacity that is relevant when an adult completes an advance health directive. This test is considered below in section 2.3.1.

[5] *Guardianship and Administration Act 2000* (Qld) s 7(a) and sch 1 s 1 and *Powers of Attorney Act 1998* (Qld) sch 1 s 1.

2.3.1 The adult has completed an advance health directive

The *Powers of Attorney Act 1998* (Qld) establishes a statutory advance directive scheme. An adult who has the requisite capacity can complete an advance health directive (AHD). The legislation contains two definitions of capacity that may be relevant in this context. The first is the three part definition of capacity set out in section 2.2 above. In addition, section 42 of the legislation provides a further definition of capacity that applies specifically to a person who wishes to complete an AHD.[6] In general terms, this provision requires the adult to be able to understand the nature and likely effects of each direction, the circumstances set out in the legislation that determine when the direction will operate, when the direction can be altered, and when the adult will no longer be able to alter the direction.

While the matter is not free from doubt, it is likely that both definitions would have to be satisfied for an adult to have the requisite capacity to complete an AHD.[7] The authors suggest that the matters referred to in section 42 provide a non-exhaustive list of matters that need to be understood for the adult to have the requisite 'understanding' for the first limb of the three-tier capacity test.

The legislation allows an AHD to contain a direction about the withholding or withdrawal of life-sustaining treatment.[8] According to the hierarchy contained within the Queensland guardianship regime, if a valid AHD exists and is relevant to the medical context, it will take priority as the valid form of consent to the provision of treatment or the withholding or withdrawal of treatment.[9]

The legislation contains some important limitations about when an AHD that withholds or withdraws life-sustaining treatment will operate. A directive cannot operate unless two, or possibly three, conditions are met, depending on the circumstances.[10] The first condition is that the adult's health must be sufficiently poor. Before the AHD can operate, the adult must fall within one of the following four categories:

- The adult must have a terminal illness (or a condition that is incurable or irreversible) from which the adult is expected to die within a year;
- The adult must be in a persistent vegetative state;
- The adult must be permanently unconscious; or

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[6] *Powers of Attorney Act 1998* (Qld) s 42.
[7] For a consideration of the arguments about whether both criteria or just the criterion that relates specifically to AHDs must be satisfied, see L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211, 218 and Queensland Law Reform Commission, *Shaping Queensland's Guardianship Legislation: Principles and Capacity*, Discussion Paper No 64 (2008) [7.62]-[7.71].
[8] Pursuant to s 35(1) of the *Powers of Attorney Act 1998* (Qld), the adult may give a direction about 'health matters'. 'Health matter' is defined in sch 2 s 4 to be a matter relating to 'health care'. 'Health care' is defined in sch 2 s 5 to include the withholding and withdrawing of a life-sustaining measure in the circumstances specified in that provision.
[9] *Guardianship and Administration Act 2000* (Qld) s 66.
[10] *Powers of Attorney Act 1998* (Qld) s 36(2).

- The adult must have an illness or injury of such severity that there is no reasonable prospect that the adult will recover to an extent that life-sustaining medical treatment will not be needed.[11]

The second condition is that the AHD can only apply if the adult has no reasonable prospect of regaining the capacity needed to make decisions about his or her health.[12]

The third condition only applies if the AHD relates to the refusal of artificial nutrition or hydration. In such a case, the directive will only operate if the commencement or continuation of the treatment would be inconsistent with good medical practice.[13]

The *Powers of Attorney Act 1998* (Qld) provides protection for medical professionals who treat patients who have completed a valid and applicable AHD that refuses life-sustaining medical treatment. First, medical professionals are protected if they comply with such an AHD by withholding or withdrawing life-sustaining treatment.[14] In addition, the legislation sets out three circumstances in which a medical professional may be protected if he or she chooses *not* to comply with a valid and applicable AHD. A medical professional is excused from not following an AHD if he or she has reasonable grounds to believe:

- that the direction is uncertain;
- that the direction is inconsistent with good medical practice; or
- circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.[15]

Role of medical professional

A medical professional has an important role to play when the AHD is completed. He or she must certify in the AHD that the adult appeared to have capacity at the time the AHD was completed.[16] To make this certification, the medical professional must be aware of the statutory criteria for capacity as considered above. As explained, however, the law regarding capacity in this context is unclear because there is some doubt about whether the legislation provides for one or two tests of capacity for an adult completing an AHD.

A medical professional will also be involved at some later point when a decision must be made about whether to withhold or withdraw treatment from an adult who lacks decision-

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[11] *Powers of Attorney Act 1998* (Qld) s 36(2)(a).
[12] *Powers of Attorney Act 1998* (Qld) s 36(2)(c).
[13] *Powers of Attorney Act 1998* (Qld) s 36(2)(b). 'Good medical practice' is defined in *Powers of Attorney Act 1998* (Qld) sch 2 s 5B by reference to recognised medical and ethical practices and standards of the medical profession in Australia.
[14] *Powers of Attorney Act 1998* (Qld) s 80.
[15] *Powers of Attorney Act 1998* (Qld) s 103. For a critique of the excuse provided by this provision, see L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211.
[16] *Powers of Attorney Act 1998* (Qld) s 44(6).

making capacity. Firstly, he or she must determine whether the AHD is valid and applicable to the medical situation that has arisen. Secondly, the medical professional must determine whether the AHD operates. That is, an assessment must be made about whether the adult is sufficiently ill, has a reasonable prospect of regaining capacity and, if the AHD relates to artificial nutrition or hydration, whether commencement or continuation of that treatment is inconsistent with good medical practice. Finally, in circumstances when the medical professional does not wish to comply with the AHD, he or she must be familiar with the excuses contained in the legislation that authorise non-compliance. If a medical professional does not comply with an AHD for other reasons, he or she may be exposed to legal liability.

Common law advance directives

Whether the common law that governs advance directives (which was considered in the first article of the series)[17] continues to apply in Queensland following the enactment of the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld) remains uncertain.

It is likely that Parliament intended the common law regime to operate alongside the statutory regime following the enactment of the guardianship legislation. The *Powers of Attorney Act 1998* (Qld) contemplates that it would not affect the common law on advance directives. Section 39 of that Act provides that '[t]his Act does not affect common law recognition of instructions about health care given by an adult that are not given in an advance health directive'. However, the *Guardianship and Administration Act 2000* (Qld), the later Act, provides that a decision about a health matter may be made *only* by a decision-maker or in a manner set out in section 66 of that Act. Section 66 does not refer to common law directives.

In relation to the continued applicability of common law advance directives, it is therefore likely that the *Guardianship and Administration Act 2000* (Qld) is not consistent with the *Powers of Attorney Act 1998* (Qld). The *Guardianship and Administration Act 2000* (Qld) provides that, to the extent that there is an inconsistency between the two Acts, the *Guardianship and Administration Act 2000* (Qld) prevails.[18] As a result, the authors are of the view that common law advance directives no longer have legal effect in Queensland.[19]

Role of medical professional

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[17] B White, L Willmott, P Trowse, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 1 (New South Wales)' (forthcoming), section 6.3.1.

[18] *Guardianship and Administration Act 2000* (Qld) s 8(2).

[19] For more detail on whether the common law governing advance directives applies in Queensland, B White and L Willmott, 'Will You Do as I Ask?' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77. This uncertainty was also observed by the Queensland Law Reform Commission in its recent review: Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper No 68 (2009) vol 1, 270-271. Note also the decision of *State of Qld v Astill* (Unreported decision, Supreme Court of Queensland, Muir J, 18 January 2006), a case in which a woman who had completed an advance directive refusing blood products was involved in a car accident and temporarily lost capacity. Because the directive did not comply with the statutory requirements in the *Powers of Attorney Act 1998* (Qld), the Supreme Court of Queensland held that it did not operate and the adult could be given a blood transfusion. The Court did not consider whether the document constituted a common law advance directive.

If the authors' interpretation above is correct, the adult is not able to give a common law advance directive and a medical professional will need to know that a purported directive of this kind is not legally binding. However, if the common law continues to operate, the medical professional will likewise need to know this and he or she will fulfil the same roles as discussed in the New South Wales article.[20]

2.3.2 A person has been appointed by the Queensland Civil and Administrative Tribunal to make health care decisions on the adult's behalf

QCAT is empowered to appoint a guardian on behalf of an adult who lacks decision-making capacity.[21] If the person is given a plenary appointment to make all personal decisions for the adult, that will include power to make decisions about health care. This power is wide enough for the guardian to make a decision about withholding or withdrawing life-sustaining treatment.[22] Alternatively, QCAT may make a more limited appointment, conferring a guardian with power to make decisions only in relation to health care. Although such appointment is limited in nature, because health care is defined to include withholding and withdrawing of life-sustaining treatment in some circumstances, that power is sufficient to enable the guardian to make such a decision.[23]

Criteria applicable to the decision

When making a decision about whether treatment should be withheld or withdrawn, the appointed guardian is required to apply[24] what are referred to as 'General Principles' and the 'Health Care Principle' which are listed in the legislation.[25] There are 11 General Principles, but those that have been identified as most relevant in a decision to withhold or withdraw life-sustaining treatment are the following:[26]

- The right of all adults to the same basic human rights, regardless of a particular adult's capacity, must be recognised and taken into account.[27]
- An adult's right to respect for his or her human worth and dignity as an individual must be recognised and taken into account.[28]
- The principle of substituted judgment must be used so that if, from the adult's previous actions, it is reasonably practicable to work out what the adult's views and

[20] B White, L Willmott, P Trowse, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 1 (New South Wales)' (forthcoming), section 6.3.1.
[21] *Guardianship and Administration Act 2000* (Qld) s 12.
[22] See n 2 above and associated text for the definition of 'health care'.
[23] Ibid.
[24] *Guardianship and Administration Act 2000* (Qld) s 34.
[25] *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), sch 1. For a consideration of the difficulties that a substitute decision-maker may encounter in applying the General Principles and the Health Care Principle in relation to these decisions, see M Howard, 'Principles for substituted decision-making about withdrawing and withholding life-sustaining measures in Queensland: a case for legislative reform' (2006) 6 *Queensland University of Technology Law and Justice Journal* 166.
[26] See eg *Re HG* [2006] QGAAT 26 where the (then) Guardianship and Administration Tribunal considered most of the General Principles listed.
[27] General Principle 2(1).
[28] General Principle 3.

wishes would be, a person must take into account what he or she considers would be the adult's views and wishes.[29]

- The importance of maintaining an adult's cultural and linguistic environment, and set of values (including any religious beliefs), must be taken into account.[30]
- Power for a matter should be exercised by a guardian, administrator or attorney for an adult in a way that is appropriate to the adult's characteristics and needs.[31]

When applying the Health Care Principle, the guardian must exercise power to make the treatment decision:

- in the way least restrictive of the adult's rights; and
- only if the exercise of power –

  (i) is necessary and appropriate to maintain or promote the adult's health or wellbeing; or

  (ii) is, in all the circumstances, in the adult's best interests.[32]

Role of medical professional

The medical professional has an important role in the process. He or she will need to be satisfied that the person is an appropriate decision-maker, namely, that he or she has been appointed by QCAT, and has the necessary power to make decisions about health care.

The medical professional also may have a role if the guardian has refused treatment. First, consent by the appointed guardian to the withholding or withdrawing of treatment will only operate if the medical professional reasonably considers that the commencement or continuation of the life-sustaining treatment for the adult to be inconsistent with good medical practice.[33] In effect, this gives the medical professional a gatekeeping role when a guardian decides to withhold or withdraw treatment.

Secondly, the medical professional can play a role if he or she believes that the guardian has made a decision to withhold or withdraw treatment without applying the General Principles or Health Care Principle appropriately. This may occur, for example, if the medical professional is concerned that the guardian is not acting in the adult's best interests or is motivated by factors other than those contained in the General Principles. In such a case, the medical professional could refer the case to the Adult Guardian[34] or could make an

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[29] General Principle 7(4). Note, however, that a person performing a function or exercising a power under the legislation must do so in a way that is consistent with the adult's proper care and protection: General Principle 7(5).

[30] General Principle 9.

[31] General Principle 10.

[32] Health Care Principle 12.

[33] *Guardianship and Administration Act 2000* (Qld) s 66A. 'Good medical practice' is defined in sch 2 s 5B by reference to recognised medical standards, practices and procedures and recognised ethical standards of the medical profession in Australia.

[34] The Adult Guardian has power to mediate and conciliate disputes that arise between a guardian and a medical professional: *Guardianship and Administration Act 2000* (Qld) ss 174(2)(c) and 175. The Adult Guardian also

application to QCAT[35] for the Tribunal to make a determination on the matter itself,[36] or to remove the existing guardian and appoint another in his or her place.[37]

2.3.3 The adult has appointed an attorney to make health care decisions on the adult's behalf

Under the *Powers of Attorney Act 1998* (Qld), an adult can complete an 'enduring power of attorney' (EPA) to appoint an 'attorney' to make decisions about personal matters on his or her behalf.[38] A 'personal matter' is defined by the legislation to include 'health care of the adult'.[39] As already established, the term 'health care' is defined broadly to include decisions about withholding and withdrawing life-sustaining treatment.[40] Therefore, an attorney under an EPA can make decisions about withholding and withdrawing life-sustaining medical treatment.

Criteria applicable to the decision

The criteria that must be taken into account by an attorney when making a decision about whether to withhold or withdraw life-sustaining medical treatment are the same as those which must be considered by a guardian appointed by QCAT, as set out above in section 2.3.2. That is, the attorney must make his or her decision in accordance with the General Principles and the Health Care Principle.[41]

Role of medical professional

The medical professional will have to be satisfied that the attorney is the relevant decision-maker, and has the necessary powers to make decisions about health care.

The medical professional also has an important gatekeeping role to play, as described in section 2.3.2 above. The attorney's consent to withhold or withdraw treatment will not operate unless the medical professional believes that commencing or continuing treatment is inconsistent with good medical practice.[42] The medical professional can also take action if the attorney has not complied with the General Principles or the Health Care Principle in making his or her decision. The medical professional could refer the case to the Adult

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has power to make a decision about a health matter if a guardian makes a decision that is contrary to the Health Care Principle: *Guardianship and Administration Act 2000* (Qld) s 43.

[35] *Guardianship and Administration Act 2000* (Qld) s 115.

[36] Consent to the withholding or withdrawal of life-sustaining treatment is a function specifically conferred upon QCAT: *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).

[37] *Guardianship and Administration Act 2000* (Qld) ss 12 and 81(1)(b).

[38] An adult may also appoint an attorney for health matters in an AHD: *Powers of Attorney Act 1998* (Qld) s 35(1)(c). This section of the article applies equally to an enduring attorney for health matters who has been appointed in this way.

[39] *Guardianship and Administration Act 2000* (Qld) sch 2 s 2 and *Powers of Attorney Act 1998* (Qld) sch 2 s 2.

[40] See n 2 above and associated text for the definition of 'health care'.

[41] *Powers of Attorney Act 1998* (Qld) s 76.

[42] *Guardianship and Administration Act 2000* (Qld) s 66A.

Guardian[43] or could make an application to QCAT[44] for the Tribunal to make a determination on the matter itself,[45] or to remove the attorney and appoint another attorney in his or her place.[46] Alternatively, QCAT could remove the attorney and appoint another person as guardian to make health care decisions.[47]

2.3.4 A person is nominated by the legislation as statutory health attorney ('default decision-maker')

The Queensland legislation facilitates the making of a decision by a substitute decision-maker even if a person has not been appointed as a guardian for personal (or health) matters by QCAT, or appointed as an attorney for personal (or health) matters under an EPA. The *Powers of Attorney Act 1998* (Qld) sets out a list of people who may be the 'statutory health attorney' of the adult and who are, as such, empowered to make a decision about the adult's health care.[48] As outlined above, this power to make a decision about health care extends to decisions concerning withholding or withdrawing life-sustaining medical treatment.

A statutory health attorney is the first person, in the list below, who is readily available and culturally appropriate to exercise power for health matters:[49]

- a spouse of the adult (if the relationship is close and continuing);
- adult's carer (if 18 years or more and is not a paid carer); and
- a close friend or relation of the adult (if 18 years or more and not a paid carer).

If there is no-one who is readily available and culturally appropriate from the list above, the Adult Guardian is the adult's statutory health attorney.[50] As such, there will always be a default decision-maker to make decisions about health care and, therefore, decisions about the withholding or withdrawing of life-sustaining treatment.

Criteria applicable to the decision

The criteria that must be taken into account by a statutory health attorney in making a decision about whether to withhold or withdraw life-sustaining treatment are the same as

[43] The Adult Guardian has power to mediate and conciliate disputes that arise between a guardian and a medical professional: *Guardianship and Administration Act 2000* (Qld) ss 174(2)(c) and 175. The Adult Guardian also has power to make a decision about a health matter if a guardian makes a decision that is contrary to the Health Care Principle: *Guardianship and Administration Act 2000* (Qld) s 43.
[44] *Guardianship and Administration Act 2000* (Qld) s 115.
[45] Consent to the withholding or withdrawal of life-sustaining treatment is a function specifically conferred upon QCAT: *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).
[46] *Powers of Attorney Act 1998* (Qld) s 116.
[47] *Guardianship and Administration Act 2000* (Qld) ss 12 and 81(1)(b).
[48] *Powers of Attorney Act 1998* (Qld) s 63 and *Guardianship and Administration Act 2000* (Qld) s 66.
[49] *Powers of Attorney Act 1998* (Qld) s 63(1).
[50] *Powers of Attorney Act 1998* (Qld) s 63(2).

those which must be considered by a guardian appointed by QCAT, as considered above in section 2.3.2, namely the General Principles and the Health Care Principle.[51]

Role of medical professional

The medical professional will have to be satisfied that the person purporting to make the decision as statutory health attorney is the appropriate decision-maker. This would require the medical professional to know about the scheme of default decision-makers, and their priority as established by the legislation. The medical professional would also need to have knowledge that the statutory health attorney has the necessary powers to make decisions about health care.

The medical professional also has an important gatekeeping role to play, as described in section 2.3.2 above. The statutory health attorney's consent to withhold or withdraw treatment will not operate unless the medical professional believes that commencing or continuing the treatment is inconsistent with good medical practice.[52] The medical professional can also take action if the statutory health attorney has not complied with the General Principles or the Health Care Principle in making his or her decision. The medical professional could refer the case to the Adult Guardian[53] or could make an application to QCAT[54] for the Tribunal to make a determination on the matter itself,[55] or to appoint another person as guardian to make health care decisions.[56]

2.3.5 Decision by (and other roles of) the Adult Guardian

The Adult Guardian is a statutory official who has been conferred with many functions under the Queensland guardianship legislation.[57] These functions include fulfilling three types of roles in these decisions. First, the Adult Guardian may act in the substitute decision-making roles already described: as a guardian appointed by QCAT for health matters,[58] an enduring attorney appointed by the adult for health matters,[59] or a statutory health attorney if no other person can act in that role.[60]

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[51] *Powers of Attorney Act 1998* (Qld) s 76.
[52] *Guardianship and Administration Act 2000* (Qld) s 66A.
[53] The Adult Guardian has power to mediate and conciliate disputes that arise between a guardian and a medical professional: *Guardianship and Administration Act 2000* (Qld) ss 174(2)(c) and 175. The Adult Guardian also has power to make a decision about a health matter if a guardian makes a decision that is contrary to the Health Care Principle: *Guardianship and Administration Act 2000* (Qld) s 43.
[54] *Guardianship and Administration Act 2000* (Qld) s 115.
[55] Consent to the withholding or withdrawal of life-sustaining treatment is a function specifically conferred upon QCAT: *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).
[56] *Guardianship and Administration Act 2000* (Qld) ss 12 and 81(1)(b).
[57] *Guardianship and Administration Act 2000* (Qld) s 174.
[58] *Guardianship and Administration Act 2000* (Qld) s 174(2)(e).
[59] *Guardianship and Administration Act 2000* (Qld) s 174(2)(d)(i)-(ii).
[60] *Guardianship and Administration Act 2000* (Qld) s 174(2)(d)(iii).

Secondly, the Adult Guardian is also granted powers to *intervene as a decision-maker* in two further situations. The first is where there is disagreement about an adult's health care by the relevant substitute decision-makers, and this disagreement cannot be resolved by the Adult Guardian through mediation.[61] The second situation is where a guardian or attorney refuses to make a decision about the health matter and doing so is contrary to the Health Care Principle, or makes a decision that is contrary to the Health Care Principle.[62] Because these powers relate to making a decision about a health matter, the power extends to decisions about withholding or withdrawing life-sustaining treatment.

Finally, and as alluded to above, the Adult Guardian also has power to act as a *mediator or conciliator* to resolve disputes that may arise in relation to health care decisions, including in relation to decisions to withhold or withdraw life-sustaining medical treatment.[63] A disagreement could arise in different contexts. First, a dispute may arise between substitute decision-makers who are responsible for making treatment decisions. Secondly, there may be disputes between what the medical professional is recommending and the treatment that the substitute decision-maker wants to occur. This may be because the decision-maker wants treatment to be given *or* not given contrary to the recommendations of the medical professional.

Criteria applicable to the decision

Regardless of whether the Adult Guardian is acting as a substitute decision-maker,[64] intervening in a dispute to make a decision, or exercising power as mediator or conciliator, the General Principles and Health Care Principle must be applied.[65]

Role of medical professional

Medical professionals need to be aware of the range of roles played by the Adult Guardian as described above. If an adult lacks capacity, the Adult Guardian may be the decision-maker in relation to health care as guardian appointed QCAT, as an enduring attorney appointed by the adult, or as statutory health attorney.

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[61] *Guardianship and Administration Act 2000* (Qld) s 42(1).
[62] *Guardianship and Administration Act 2000* (Qld) s 43(1).
[63] *Guardianship and Administration Act 2000* (Qld) s 174(2)(c).
[64] In relation to the General Principles and Health Care Principle that are relevant to this decision, see the earlier discussion in section 2.3.2 above.
[65] Although the criteria that are relevant for each of these roles are the General Principles and Health Care Principle, it is likely that the legislative provision that directs application of or compliance with these principles will vary, depending on the role that is being performed. For example, if the Adult Guardian is the decision-maker as guardian appointed by QCAT, the relevant provision is s 34 *Guardianship and Administration Act 2000* (Qld) while if acting as attorney under an EPA or as statutory health attorney, the relevant provision is s 76 *Powers of Attorney Act 1998* (Qld). In relation to the Adult Guardian's role when intervening as decision-maker, and as mediator or conciliator, it is likely that the relevant provision is s 11 *Guardianship and Administration Act 2000* (Qld) which operates more broadly to persons and entities performing functions or exercising roles under the legislation.

Again, as for the other substitute decision-makers, the medical professional may not act on the consent of the Adult Guardian to withhold or withdraw treatment unless it would be inconsistent with good medical practice to continue or commence treatment.[66] In the unlikely event that the medical professional considers that the Adult Guardian has not complied with the General Principles or the Health Care Principle in making a decision about health care, the medical professional could make an application to QCAT[67] for the Tribunal to make a determination on the matter itself,[68] or to remove the Adult Guardian and appoint another guardian instead.[69]

The second role of the Adult Guardian, identified above, is to intervene and make the decision about withholding or withdrawing treatment. In such a case, the Adult Guardian's power to make the decision stems from the power to intervene in the matter. That is, it has a different statutory origin than if the Adult Guardian made the decision as guardian appointed by QCAT, or as attorney appointed by the adult, or as statutory health attorney. As described in the previous paragraph, if the Adult Guardian makes a decision as guardian, attorney or statutory health attorney, the medical professional has a gatekeeping role in that consent will only operate if the provision of the treatment is inconsistent with good medical practice. Where the Adult Guardian makes a decision after intervening in the matter, it appears that the medical professional does not have this gatekeeping role.[70] Nevertheless, if the medical professional believes that the Adult Guardian has not complied with the General Principles or the Health Care Principle, the other avenues available to him or her as described in the previous paragraph will still apply.

A medical professional should also be aware of the role of the Adult Guardian in conciliating and mediating disputes, as this may provide a satisfactory means of resolving disputes that arise when a decision needs to be made about withholding or withdrawing life-sustaining treatment.

2.3.6 Order of the Queensland Civil and Administrative Tribunal

QCAT itself also has power to make a decision about withholding or withdrawing life-sustaining treatment.[71] The Tribunal most commonly makes this kind of decision if

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[66] *Guardianship and Administration Act 2000* (Qld) s 66A.
[67] *Guardianship and Administration Act 2000* (Qld) s 115.
[68] Consent to the withholding or withdrawal of life-sustaining treatment is a function specifically conferred upon QCAT: *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).
[69] *Guardianship and Administration Act 2000* (Qld) ss 12 and 81(1)(b).
[70] This outcome arises as a matter of statutory interpretation. The gatekeeping function of a medical professional arises under s 66A of the *Guardianship and Administration Act 2000* (Qld) which applies to a matter involving the withholding or withdrawing life-sustaining treatment under s 66(3), (4) or (5) of the same Act. These provisions apply to guardians, attorneys and statutory health attorneys. They do not include the decision-making power of the Adult Guardian that arises when intervening in a dispute pursuant to ss 42 and 43 of the *Guardianship and Administration Act 2000* (Qld).
[71] *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).

disagreement occurs between family members or between family members and others, including medical professionals, interested in the care of the adult.[72]

Criteria applicable to the decision

As for the other decision-makers, the relevant General Principles and Health Care Principle must guide QCAT's decision.[73]

Role of medical professional

As for other decision-makers considered above, the medical professional should be aware of QCAT's power to make such a decision about withholding or withdrawing life-sustaining treatment.

One issue worth noting is that the gatekeeping role of the medical professional that was discussed above in the context of other substitute decision-makers applies also where the decision to withhold or withdraw treatment is made by QCAT. It will be recalled that, pursuant to s 66A of the *Guardianship and Administration Act 2000* (Qld), consent to the withholding or withdrawal of treatment cannot operate unless the medical professional considers the provision of that treatment to be inconsistent with good medical practice. This provides a safeguard so that consent to withholding or withdrawal is not acted upon in inappropriate cases. It is therefore surprising that the safeguard also applies where the matter has been determined by QCAT. Nevertheless, this appears to be the result as a matter of statutory construction,[74] and that interpretation has also been confirmed in a QCAT decision.[75]

2.4 Category 2 – medical professional considers life-sustaining treatment to be futile

Under the Queensland guardianship legislation, consent must be obtained for all health care provided to an adult with the exception of minor and uncontroversial health care,[76] and health care that is provided or withheld or withdrawn in urgent circumstances.[77] The definition of 'health care' includes decisions about withholding or withdrawing life-sustaining medical treatment.[78] The legislation does not treat futile treatment differently from other treatment. This means that a medical professional must obtain consent to withhold or withdraw

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[72] See eg *Re HG* [2006] QGAAT 26 and *Re SAJ* [2007] QGAAT 62.
[73] *Guardianship and Administration Act 2000* (Qld) s 11(1). See also *Re HG* [2006] QGAAT 26, [67].
[74] The safeguard contained in s 66A of the *Guardianship and Administration Act 2000* (Qld) is stated to apply if the 'matter concerning the withholding or withdrawal ... is to be dealt with under section 66(3), (4), or (5)'. Section 66(3) refers to situations where 'the tribunal has ... made an order about the matter' which would be the case where it has consented to the withholding or withdrawal of treatment.
[75] *Re HG* [2006] QGAAT 26, [31]. For a full discussion of the legal arguments as to why this is the case, see L Willmott and B White, 'Charting a Course through Difficult Legislative Waters: Tribunal Decisions on Life-Sustaining Measures' (2005) 12 *Journal of Law and Medicine* 441.
[76] *Guardianship and Administration Act 2000* (Qld) s 64.
[77] *Guardianship and Administration Act 2000* (Qld) ss 63 and 63A.
[78] See n 2 above and associated text for the definition of 'health care'.

treatment from an adult even if he or she considers that treatment to be futile.[79] The consent mechanisms that were considered in section 2.3 above will therefore apply.

Role of medical professional

Although a medical professional may form a view that giving life-sustaining treatment to an adult is futile, that medical professional is not the legal decision-maker. If consent is not given to withhold or withdraw treatment, treatment may need to be provided until consent to withhold or withdraw is obtained through another mechanism.

There are four avenues that a medical professional can pursue if faced with such a situation. First, he or she may seek to access the mediation and conciliation services that the Adult Guardian provides.[80] Secondly, the medical professional may contact the Adult Guardian and ask that the Adult Guardian consents to the withholding or withdrawing of treatment. The Adult Guardian has power to do so if of the view that the substitute decision-maker is refusing to make a decision and that failure to make a decision is contrary to the Health Care Principle,[81] or that a decision has been made by the substitute decision-maker in a manner that is contrary to the Health Care Principle.[82] Thirdly, a medical professional may bring an application to QCAT for the appointment of another substitute decision-maker or to obtain the Tribunal's consent to the withholding or withdrawal of treatment.[83] Fourthly, a medical professional may seek redress outside the statutory regime by applying to the Queensland Supreme Court for relief pursuant to its *parens patriae* jurisdiction.[84]

2.5 Category 3 – urgent decision about life-sustaining treatment is required

As outlined in the first article of this series, there may be some circumstances where an urgent decision is required in relation to the withholding or withdrawing of life-sustaining medical treatment. In Queensland, a medical professional is given powers to both provide *and* withhold or withdraw treatment in an urgent context. The power to provide treatment in such a context without the need to first obtain consent is not surprising, and is consistent with the position in the other two jurisdictions.[85] The Queensland context is different from New South Wales and Victoria, however, in that consent must also be obtained to withhold or

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[79] B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) ISBN 1 74107 090 2 pp 69-72 (available at http://www.law.qut.edu.au/files/QUT_LifeSustainingIssuesPaper.pdf). This view is consistent with the Coronial findings in the *Inquest into the Death of June Woo* (Unreported, Queensland Coroner's Court, State Coroner Barnes SM, 1 June 2009) 19-23.
[80] *Guardianship and Administration Act 2000* (Qld) s 174(2)(c). See further section 2.3.5 above.
[81] *Guardianship and Administration Act 2000* (Qld) s 43(1)(a).
[82] *Guardianship and Administration Act 2000* (Qld) s 43(1)(b).
[83] *Guardianship and Administration Act 2000* (Qld) s 115.
[84] See section 3 below for more detail about the Supreme Court's *parens patriae* jurisdiction.
[85] *Guardianship and Administration Act 2000* (Qld) s 63. The position in New South Wales is considered in B White, L Willmott, P Trowse, M Parker, C Cartwright, 'The Legal Role of Medical Professionals in Decisions to Withhold or Withdraw Life-Sustaining Treatment: Part 1 (New South Wales)', section 6.5, and in Victoria, L Willmott, B White, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)' (forthcoming), section 2.5.

withdraw treatment even if the treatment is regarded as futile.[86] The legislation, therefore, would have to expressly confer on medical professionals the power to withhold or withdraw treatment in an urgent context for them to have the authority to do so, even if the provision of the treatment would be futile. Such power is conferred by the *Guardianship and Administration Act 2000* (Qld). A medical professional is empowered to withhold or withdraw life-sustaining medical treatment without obtaining consent where:

- the commencement or continuation of the life-sustaining medical treatment is inconsistent with good medical practice; and
- consistent with good medical practice, the decision to withhold or withdraw treatment must be taken immediately.[87]

A medical professional may not, however, withhold or withdraw treatment if he or she is aware that the adult objects to that course of conduct.[88]

Criteria applicable to the decision

The criteria that must be satisfied before a medical professional can withhold or withdraw treatment without consent is set out in the section, that is providing the treatment must be inconsistent with good medical practice, and good medical practice requires that the decision must be taken immediately.[89] 'Good medical practice' is defined by reference to recognised medical standards, practices and procedures, and ethical standards of the medical profession in Australia.[90] In exercising the power to withhold or withdraw treatment, the medical professional would also have to apply the General Principles and Health Care Principle.[91]

Role of medical professional

In the context of an urgent decision to withhold or withdraw treatment, the medical professional is the decision-maker.[92] He or she would therefore need to know that this power exists, the circumstances in which it can be exercised, and the criteria that should guide the exercise of the power.

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[86] See section 2.4 above.
[87] *Guardianship and Administration Act 2000* (Qld) s 63A(1).
[88] *Guardianship and Administration Act 2000* (Qld) s 63A(2).
[89] *Guardianship and Administration Act 2000* (Qld) ss 63A(1)(b) and (c).
[90] *Guardianship and Administration Act 2000* (Qld) sch 2 s 5B.
[91] *Guardianship and Administration Act 2000* (Qld) s 11(1). Note that an argument has been advanced that s 11(1) does not directly require medical professionals, who are not substitute decision-makers, to apply the General Principles or Health Care Principle. This argument is supported, in part, by the drafting of the Health Care Principle, which refers only to the principle applying to guardians, attorneys, the Adult Guardian and QCAT in relation to health matters. On balance, however, the authors are of the view that medical professionals are 'authorised' by the legislation to withhold or withdraw treatment in an acute emergency, and this is a sufficient 'power' to invoke s 11(1): *Acts Interpretation Act 1954* (Qld) s 36. In any event, s 11(3) of the *Guardianship and Administration Act 2000* (Qld) encourages 'the community' to apply and promote the General Principles.
[92] Note, however, that a medical professional is not technically classed as a substitute decision-maker under the guardianship regime: *Guardianship and Administration Act 2000* (Qld) s 9.

3. Order of the Supreme Court exercising its *parens patriae* jurisdiction

The Supreme Courts of New South Wales, Queensland and Victoria, all have a *parens patriae* jurisdiction, which enables these Courts to make decisions in relation to adults who lack capacity.[93] Although most matters involving decisions about withholding or withdrawing life-sustaining treatment from such adults will be resolved under the guardianship legislation which has been described in this series of articles, the *parens patriae* jurisdiction provides an important alternative legal pathway that may be, and has been, used in cases of this kind.[94]

In *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)*,[95] the High Court of Australia acknowledged that the *parens patriae* jurisdiction 'springs from the direct responsibility of the Crown for those who cannot look after themselves; it includes infants as well as those of unsound mind.'[96] Thus, the underlying purpose of the jurisdiction is to protect the 'life and bodily integrity of persons who are unable to do so for themselves because of various exigencies…'.[97]

The scope of the *parens patriae* jurisdiction is wide, and includes the power to authorise the provision of medical treatment, or to provide consent to treatment on behalf of the adult who is incapable of providing that consent.[98] The provision of authorisation or consent by the Court makes the provision of treatment, or the withholding or withdrawal of that treatment, lawful. Despite the wide nature of the jurisdiction, it should be noted that the court exercises the jurisdiction with caution.[99] The Court will not intervene lightly in a decision that has been made to withhold or withdraw treatment.

That said, there have been a number of important Australian cases where the various Supreme Courts have exercised their *parens patriae* jurisdiction in the context of withholding

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[93] It should also be noted that the Supreme Courts may also be able to resolve issues related to withholding or withdrawing life-sustaining measures from adults who lack capacity by providing declaratory relief that such a course would be lawful. For a more detailed discussion of this form of relief, see L Willmott, B White and S Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Thomson, 2010) [13.90].

[94] The *parens patriae* jurisdiction continues to exist in all three jurisdictions examined in this series of articles, notwithstanding the enactment of guardianship legislation which also exists for the protection of adults who lack capacity. The High Court has stated that the *parens patriae* jurisdiction may only be removed 'expressly or by necessary, indeed inescapable, implication': *Minister for Interior v Neyens* (1964) 113 CLR 411 at 419 (Barwick CJ). Note that the New South Wales and Queensland legislation have expressly retained the *parens patriae* jurisdiction: *Guardianship Act 1987* (NSW) ss 8, 31, 31G and *Guardianship and Administration Act 2000* (Qld) s 240 and *Powers of Attorney Act 1998* (Qld) s 109. In relation to Victoria, see *Re BWV; ex parte Gardner* (2003) 7 VR 487, 510.

[95] (1992) 175 CLR 218.

[96] Ibid, 259.

[97] *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 553.

[98] *MAW v Western Sydney Area Health Service* (2000) 49 NSWLR 231 at 238 (O'Keefe J).

[99] *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 280 (Brennan J); *Slaveski v Austin Health* [2010] VSC 493, [34] (Dixon J); *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 547, 554 (O'Keefe J); *MAW v Western Sydney Area Health Service* (2000) 49 NSWLR 231, 238 (O'Keefe J).

and withdrawing life-sustaining treatment. Applications to the Supreme Court are most commonly made where the treating team has decided not to provide active treatment and the family is seeking to overturn that decision.[100]

Northridge v Central Sydney Area Health Service[101] provides a good illustration of the exercise of the *parens patriae* jurisdiction. In this case, a 37 year old male had suffered a cardiac arrest following a heroin overdose. Within a week of admission, he was diagnosed as being in a 'chronic vegetative state'.[102] Antibiotic treatment was ceased and his nasogastric feeding tube removed against the wishes of his family, who believed he had prospects of recovery. As a result, the adult's sister applied to the New South Wales Supreme Court for an order to reinstate treatment. The Court was critical of the decision to withdraw treatment and concluded that it had been made prematurely. It therefore granted the relief sought by the sister.

Criterion applicable to the decision

The criterion that is applied by the Supreme Courts when exercising this jurisdiction is 'the protection of the best interest of the health and welfare of the person the subject of its exercise'.[103] It is impossible to set bounds as to the factors of relevance in terms of a 'best interests' or 'welfare' consideration.[104] However, it appears that the concept of best interests extends beyond purely medical considerations and therefore, ethical, social, moral and welfare considerations which are broader than those of a medical nature must be taken into account.[105] The adult's welfare, in a broad sense, is the paramount consideration.[106]

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[100] See eg *Slaveski v Austin Health* [2010] VSC 493; *In the Application of Herrington; Re King* [2007] VSC 151; *Melo v Superintendent of Royal Darwin Hospital* [2007] NTSC 71; *Messiha v South East Health* [2004] NSWSC 1061; *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549.

[101] (2000) 50 NSWLR 549.

[102] Ibid 559, 567. The court found this diagnosis was premature. The medical evidence revealed that a diagnosis of 'persistent vegetative state' is not usually made until 6-12 months after a cerebral injury. The court noted there is 'no adopted or recognised standard in Australia in relation to the making of such a diagnosis.' The United Kingdom has published guidelines and criteria which must be met before a diagnosis of permanent vegetative state is made, and before there can be termination of artificial feeding, treatment and support. One of the four criteria was that such a diagnosis cannot be made until the patient has been in a permanent vegetative state following a head injury for more than 12 months or following other causes of brain damage for more than 6 months.

[103] *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554 and *Slaveski v Austin Health* [2010] VSC 493, [34] referring to the criterion as discussed by the High Court in *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1992) 175 CLR 218, 240, 249, 252, 270-273, 295, 300, 316. There are many other formulations of this criterion. See eg *In the Application of Herrington; Re King* [2007] VSC 151, [22]; *Melo v Superintendent of Royal Darwin Hospital* [2007] NTSC 71, [25]; *Messiha v South East Health* [2004] NSWSC 1061, [25].

[104] *An NHS Trust v A* [2005] EWCA Civ 1145 [78]. For a discussion of relevant factors, see eg *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554; *In the application of Herrington; Re King* [2007] VSC 151, [24]; *Melo v Superintendent of Royal Darwin Hospital* [2007] NTSC 71, [27]; *Messiha v South East Health* [2004] NSWSC 1061, [24]-[25].

[105] *An NHS Trust v A* [2005] EWCA Civ 1145 [91] refers to *Re S* [2001] Fam 15, 28 (Butler-Sloss P).

[106] Ibid [78].

The case law has provided some assistance as to the meaning of 'best interests' in the context of decisions to withhold or withdraw life-sustaining medical treatment, and the following observations can be made. First, the provision of futile treatment will not be in a person's best interests.[107] As a result, a medical professional is not under a duty to provide such treatment.'[108] Secondly, in assessing what is in the person's best interests, both the benefits and burdens of the treatment will be considered. As part of a best interests assessment, some of the Australian decisions have considered whether the treatment is burdensome or intrusive,[109] or whether it is subjecting the person to unwarranted pain or indignity.[110] Thirdly, if the Court is called upon to adjudicate, it is not bound by the views of the medical profession and will reach its own independent assessment of what the adult's best interests require. Nevertheless, when determining whether treatment should be provided, the courts have stated that the 'decision as to appropriate treatment … is principally a matter for the expertise of professional medical practitioners'.[111]

The issue of the patient's best interests was considered by the New South Wales Supreme Court in *Messiha v South East Health.*[112] The patient in that case was an unconscious 75 year old male diagnosed with severe hypoxic brain damage, and the medical professionals had decided to cease active treatment and provide him with palliative care. In an application brought by the patient's family to prevent the withdrawal of treatment, the Court heard evidence from three medical practitioners (one of whom was engaged by the family) that there was no prospect of a significant recovery for the adult and that the treatment would only briefly prolong his life. The medical opinion was unanimous that further treatment was futile and that the continued treatment imposed burdens upon the adult in the form of infection and other complications. The Court therefore declined to provide the relief sought by the patient's family, finding that the provision of active treatment would not be in his best interests.

Role of medical professional

Medical professionals should be aware of the *parens patriae* jurisdiction of the Supreme Court and the power of that Court to consent to or authorise treatment, and also to its power to decline to do so. In an appropriate case, the medical professional (or his or her hospital) may be the applicants in the matter. This may be a possible response if the treating team

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[107] *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197 at [27]; *In the matter of Herrington; Re King* [2007] VSC 151 at [24]-[25]; *Messiha v South East Health* [2004] NSWSC 1061 at [26]. See also *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 at 554.
[108] *Airedale NHS Trust v Bland* [1993] AC 789, 858-859 (Lord Keith), 869 (Lord Goff), 884-885 (Lord Browne-Wilkinson), 898 (Lord Mustill). See also *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 251 and *Messiha v South East Health* [2004] NSWSC 1061.
[109] *Messiha v South East Health* [2004] NSWSC 1061 at [22], [23] and [28].
[110] *In the matter of Herrington; Re King* [2007] VSC 151 at [14].
[111] See *Messiha v South East Health* [2004] NSWSC 1061, [25]. See also the observation of Howie J in *Messiha v South East Health* [2004] NSWSC 1061 at [25] that the Court is not bound to give effect to medical opinion, even where the opinion is unanimous, but that it would be unusual for the Court not to do so.
[112] [2004] NSWSC 1061.

wishes to withdraw treatment, but such action is being resisted by the family. This relief may be particularly valuable if there is some doubt about whether withdrawing or withholding the treatment would be lawful, or if the family is threatening to bring legal action against the medical professional or hospital.

4. Conclusions on the law

4.1 Some problems with the law in Queensland

There has been considerable literature that has critiqued the Queensland legislation. Some of that critique has focused on the policy that underpins the legislation, such as the limitations on when an AHD that refuses life-sustaining medical treatment can operate,[113] or the excuses that are available to a medical professional for not following a valid and applicable advance directive.[114] Some critique has considered technical aspects of the legislation including the problematic definitions of 'health care' and 'life-sustaining measure'.[115] Further, there are some technical problems with the legislation which can potentially affect medical professionals who purport to practise in compliance with the law. For example, there are some concerns about the extent to which a medical professional who withdraws or withholds life-sustaining treatment with the appropriate consent of a substitute decision-maker is protected from criminal liability,[116] about the extent to which medical professionals are protected if they rely on an 'invalid' AHD,[117] or if they provide treatment with no knowledge that an AHD exists.[118] There is also uncertainty about whether a medical professional will be protected if he or she relies on an AHD that is not the original or certified as prescribed in the legislation.[119]

It is beyond the scope of this article to consider all of the problematic aspects of the Queensland legislation. Instead, the focus in this section will be on the problems that have been identified in this article which are relevant to the extent that they may impede a medical professional having an understanding of the law in this field. We note also that the broader problem of the law being generally complex is dealt with in the third article in the series.

4.1.1 Potential obligation to provide futile treatment

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[113] L Willmott, 'Advance directives to withhold life-sustaining medical treatment: Eroding autonomy through statutory reform' (2007) 10 *Flinders Journal of Law Reform* 287.
[114] See eg L Willmott, 'Advance directives and the promotion of autonomy: A comparative Australian statutory analysis' (2010) 17 *Journal of Law and Medicine* 556; L Willmott, B White and M Howard, 'Refusing advance refusals: Advance directives and life-sustaining medical treatment' (2006) 30 *Melbourne University Law Review* 211.
[115] B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) Queensland University of Technology <http://eprints.qut.edu.au/7093/> at 27 September 2010, 73-80.
[116] B White, L Willmott and J Allen, 'Withholding and withdrawing life-sustaining treatment: Criminal responsibility for established medical practice?' (2010) 17 *Journal of Law and Medicine* 849.
[117] B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) Queensland University of Technology <http://eprints.qut.edu.au/7093/> at 27 September 2010, 35-41.
[118] B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) Queensland University of Technology <http://eprints.qut.edu.au/7093/> at 27 September 2010, 42-44.
[119] B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) Queensland University of Technology <http://eprints.qut.edu.au/7093/> at 27 September 2010, 48-51.

As explained earlier, the Queensland legislation requires medical professionals to obtain consent to withhold or withdraw life-sustaining medical treatment. This obligation exists whether or not commencing or continuing the treatment is in the patient's best interests. As identified, this can be problematic for a medical professional who has assessed the provision of further treatment as futile, yet the substitute decision-maker (typically a family member) is refusing to consent to the withholding or withdrawal of treatment. Although there are legal mechanisms to address this difficult situation, a medical professional may need to provide that treatment until an alternative authority to withhold or withdraw treatment is obtained.

This is likely to present challenges to medical professionals knowing the law. Requiring consent to stop providing futile treatment is inconsistent with good medical practice, and likely also to be contrary to his or her ethical obligations. It would be reasonable for a medical professional to assume that sound medical and ethical practice would also be lawful, so the current position is likely to present barriers to knowledge. This is particularly so given that Queensland law is out of step with the law in other Australian jurisdictions under which a medical professional is not obliged to provide such treatment.

4.1.2 Uncertain status of common law advance directives

As explored above,[120] it is uncertain whether common law advance directives will be recognised in Queensland following the enactment of the guardianship legislation. There has been no express consideration of the matter by the Queensland Supreme Court or by QCAT. This uncertainty is likely to be problematic for a medical professional who is treating an adult who now lacks capacity in the following situation. The adult has completed an advance directive that is valid and applicable under the common law, but which does not satisfy the statutory requirements. If treatment is withheld in reliance on the common law advance directive and that directive is subsequently held not to have legal effect, the medical professional will be legally vulnerable. Potential liability may also arise if the adult is treated contrary to the directive, and the directive is later found by the Supreme Court or QCAT to be binding on the medical professional.

Such uncertainty is clearly undesirable, and places a medical professional who is confronted with a common law advance directive that refuses life-sustaining treatment in an untenable position. The uncertainty of the law also makes it impossible for the medical professional to know what is required of them.

4.1.3 Different definitions of capacity for advance health directives

A final challenge for medical professionals arises when they are called upon to certify that an adult has capacity to complete an AHD. The two tests that must potentially be satisfied before an adult will be regarded as having capacity were outlined earlier.[121] Until the law on this point is settled, it will be impossible for a medical professional to be confident of the extent of their obligations when attesting to the capacity of the adult who is completing the AHD.

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[120] Section 2.3.1.
[121] Ibid.

4.2 Legal role of medical professionals

Consistent with what was concluded in the first article, the analysis of the Queensland law has revealed that medical professionals play three significant legal roles in the decision-making process concerning the withholding and withdrawing of life-sustaining measures.

4.2.1 Medical professional as legal decision-maker

Although the medical professional has a significant involvement in all cases where the withholding or withdrawing of a life-sustaining measure is in question, it is only in cases of urgency that the medical professional has the lawful authority to provide treatment or withhold or withdraw treatment without first obtaining consent. In these contexts, the medical professional has the responsibility for making the decision about treatment.

4.2.2 Medical professional making decisions about how to apply the law

In addition, even where the medical professional is not the decision-maker, he or she performs a range of important legal roles in the context of these kinds of decisions. First, the medical professional must assess whether or not the patient has decision-making capacity. If the patient does not, the substitute decision-making regime is triggered. Knowledge of the legal test for capacity is therefore required.

Secondly, if the adult lacks capacity, the medical professional must be able to determine the relevant decision-maker. If the adult has made an AHD, the medical professional needs to be able to determine if it is valid, applicable to the situation that has arisen, whether the circumstances in which it can operate have been satisfied, and when a medical professional is excused for non-compliance. If the adult has not completed an AHD, the medical professional will need to be able to determine the substitute decision-maker who has authority to decide about withholding or withdrawing treatment.

Finally, the medical professional should be familiar with the criteria that the decision-maker must apply in deciding whether treatment should be withheld or withdrawn.

4.2.3 Medical professional as legal gatekeeper

In Queensland, the medical professional also has a key role as legal gatekeeper. First, a consent given by a substitute decision-maker cannot operate unless the medical professional is of the view that providing the treatment would be inconsistent with good medical practice. Secondly, where the medical professional is of the view that a substitute decision-maker has made a decision that is contrary to the Health Care Principle, or is refusing to making a decision and that refusal is contrary to the Health Care Principle, he or she can call upon the Adult Guardian to make a decision about treatment. As an alternative, the Adult Guardian may be called upon to mediate or conciliate the dispute. Thirdly, the medical professional may wish to apply to QCAT to determine the matter, or bring an application in the Supreme

Court pursuant to its *parens patriae* jurisdiction. This expansive role played by medical professionals can only be practically effective if these professionals are aware of their ability to take such action across the indicated range of situations.

Medical professionals also play a gatekeeping role if an adult completes an AHD. They must be satisfied that the adult had the requisite capacity before completing the directive. The extent to which a medical professional can adequately perform this function depends on him or her being aware of the legal obligations regarding witnessing, and an understanding of the legal test for capacity.

PART III – MEDICAL PROFESSIONALS' KNOWLEDGE OF THEIR LEGAL ROLE

5. What are medical professionals taught about this area of law?

In the first article in this series,[122] the authors indicated that there has been a generational change in medical education in recent decades, as a result of which the current cohorts of junior doctors, and certainly current medical students, have been and are being exposed to considerably more medical ethics and health law, including issues arising at the end of life, than hitherto. This will continue to be the case, as mandated by the accrediting body for medical education in Australasia, the Australian Medical Council.

In recent years, the number of medical schools in Queensland has increased from one to four, largely in response to medical workforce concerns, in particular the provision of medical services to rural and remote areas. To our informal survey of medical schools in New South Wales, Victoria and Queensland, referred to in the first article, covering decision-making capacity and capacity determination, ethical and legal aspects of withdrawing and withholding treatment (patients with and without capacity), substitute decision-making and guardianship, and advance care planning, we received responses from two of the four Queensland schools. In both these schools, there was considerable teaching provided across all the topic areas listed, via lectures and symposia. At one of the schools, Queensland's Adult Guardian personally participates in two teaching sessions that describe the State's guardianship legislation. As in New South Wales, we have informal reason (personal communication with colleagues) to believe that it is likely that the other two schools provide some teaching in these areas, although it may not be to the same extent. The depth of knowledge provided in these undergraduate teaching sessions is not equivalent to that described in this series of articles as being necessary for medical professionals to practise in compliance with the relevant legal regimes.

[122] B White, L Willmott, P Trowse, M Parker, C Cartwright, 'The Legal Role of Medical Professionals in Decisions to Withhold or Withdraw Life-Sustaining Treatment: Part 1 (New South Wales)', section 9.

As stated in the first article, there is no evidence we are aware of that systematic teaching in these areas for junior doctors is occurring in any of the three States under review, and there are few, if any, required core units in any areas of medical law, let alone the areas of interest here, at the specialist college stages of training. The provision of continuing education in medical and health law in the private practice setting is also sporadic at best. Together with considerations of the depth of teaching at the undergraduate level, this suggests that there needs to be significant improvement in the continuum of educational strategies in this area, between the undergraduate and postgraduate phases of medical practice.

6. What do medical professionals know of this area of law?

Little systematic research has been carried out to answer this question. One recent study demonstrated significant variation in the clinical assessment of decision-making capacity between health professionals (not just medical professionals) based on a survey of 285 decisions of the Queensland Guardianship and Administration Tribunal (the predecessor to QCAT) delivered between 2005 and 2008.[123] In this study, 216 of the cases involved a Tribunal decision about capacity; of these, 94 involved evidence on capacity from two or more health professional experts. Of these 94, 27 (28.7%) exhibited disagreement between the experts on whether or not the person under review possessed capacity.

Capacity assessment is a crucial clinical, ethical and legal component of the decision-making processes that occur under guardianship legislation. It is true that assessing capacity is frequently not a straight-forward task, and we should expect at least some variation on the part of assessors of good faith. Nevertheless, the variation recorded in this study, together with and presumably related to the finding of wide variation in assessment frameworks and instruments employed, suggests considerable room for improvements in systematisation, education and training. While it did not directly measure medical professionals' (and other health professionals') knowledge of the law, a number of the cases studied suggested a lack of clarity on the part of medical and health professionals about the legal definition of capacity, the nature of acceptable evidence for capacity, and the law's fundamental presumption of capacity.

A recent decision of Queensland's State Coroner,[124] while the evidence it provides pertains to a single case, sheds further light on medical professionals' knowledge of the law. An elderly female patient, June Woo, was admitted to a Queensland tertiary hospital in 2002, following multiple admissions over the preceding twelve years for chronic respiratory and renal problems. On this occasion, it was thought after a short period of initial aggressive management, that further treatment was futile, and a not-for-resuscitation order was instituted, with the apparent agreement of family members. A complex history of coronial

[123] M Parker, 'Patient Competence and Professional Incompetence: Disagreements in Capacity Assessments in One Australian Jurisdiction, and Educational Implications' (2008) 16 *Journal of Law and Medicine* 25.
[124] *Inquest into the Death of June Woo* (Unreported, Queensland Coroner's Court, Queensland Coroner's Court, State Coroner Barnes SM 1 June 2009).

involvement ensued, following family complaints of inappropriate treatment. At the final inquest in 2009, the Coroner determined that the treating medical professionals' standard of medical care was appropriate, and that they were entitled to consider that they had the consent of the family to withhold treatment they deemed futile. Nevertheless, there was evidence before the Coroner that the treating medical professional who imposed the not-for-resuscitation order was unaware of the legal requirement to first obtain consent from a substitute decision-maker. It appears that the medical professionals' actions were based on the erroneous assumption that the common law governed the withholding of futile treatment so that consent was not required to withhold futile treatment. Moreover, the Coroner was critical of the hospital over its failure to provide up-to-date guidance to its clinicians in relation to these end-of-life situations in the context of the legislation.

Although this account describes only one case, it demonstrates the likelihood of more widespread ignorance of the law, given that a major tertiary hospital, an important player in public health care provision in the State, had failed to keep current its relevant policy. While this policy failure partly explains the knowledge gap in this instance, there are also individual responsibilities regarding legal knowledge involved. Whatever one thinks of the legal requirement to obtain consent for withholding futile treatment (which, as has been observed in this article,[125] is well out of step with the common law), clinicians were apparently not aware of the prevailing regime.

There is thus at least some empirical evidence,[126] and certainly case-based information, that suggests that medical professionals in Queensland are not au fait with the law governing the withdrawal or withholding of treatment from adults who lack decision-making capacity in Queensland. This is not a surprising conclusion, but it is also not a desirable one.

PART IV: CONCLUSION

This was the second in a series of three articles looking at medical professionals' knowledge of the law governing withholding and withdrawing life-sustaining treatment in New South Wales, Queensland and Victoria. The focus of this article is on the position in Queensland. The first article explained that the series makes four claims. The first is that medical professionals play a significant legal role in decisions to withhold and withdraw treatment from individuals who lack capacity. Part II of this article explores the legal framework in Queensland which includes both the guardianship legislation and the common law. This

[125] Section 3 above.

[126] See also the results of research carried out by MA Steinberg, CM Cartwright, JM Najman, SM MacDonald and GM Williams, *Healthy Ageing, Healthy Dying: Community and Health Professional Perspectives on End-of-Life Decision-Making*, Report to the Research and Development Grants Advisory Committee of the Commonwealth Department of Human Services and Health, February 1996. As part of this study, 1129 health professionals, comprised of general practitioners, specialists and nurses, were surveyed. While the primary focus of the survey was not to test the knowledge of the health professionals on the law concerning withholding and withdrawing life-sustaining treatment, the responses to at least one question suggested knowledge gaps in relation to the (then) powers of an attorney under an enduring power of attorney.

review demonstrates, as was the position in New South Wales, that medical professionals play important roles as decision-maker, when making decisions as to how to apply the law, and also as legal gatekeeper.

The second claim is that it is important that medical professionals know the law in this area. The bases for this claim, which centred on the adverse consequences that can flow from unlawful actions, were explored at length in Part II of the first article. These arguments apply equally in the Queensland context.

Thirdly, it was claimed that there are gaps in what medical professionals know of the law in this field. There is limited empirical and other data that is available in Queensland to support or refute this claim. However, the data that exists suggests that medical professionals may not have a strong grasp of this law. Relevant in this regard is the review of clinical assessments of capacity performed by medical (and other health) professionals as revealed in Tribunal decisions over a four year period. There was a considerable divergence in assessments, and it is possible that at least some of the disparity may be because such professionals are not familiar with (and therefore use different formulations of) the test for capacity. Secondly, the Coronial findings in the *Inquest into the Death of June Woo*[127] revealed both a lack of knowledge of the law of the medical professional who imposed a not-for-resuscitation order, as well as systemic problems in that the hospital involved did not have a legally compliant policy on such orders.

The final claim is that the current state of the law is likely to impede medical professionals' knowledge. In the Queensland context, the requirement for medical professionals to obtain consent before futile treatment can be withheld or withdrawn is a classic illustration of this point. Good medical and ethical practice, as well as the law in other Australian jurisdictions, does not require medical professionals to obtain consent in such circumstances. A law which does not reflect standards of medical or ethical practice is likely to impede medical professionals from understanding and knowing such law.

This series of articles also reaches two conclusions. One relates to the need to improve the training of medical professionals. This article comments on aspects of the training that students and medical professionals currently receive, and suggests that improvement is needed. More detailed conclusions about medical training across all three jurisdictions are considered in the third article.

The second conclusion is that law reform is needed. The third article considers the need for law reform in New South Wales, Queensland and Victoria, and makes some general comments about the complexity of the law in this field. At this point, however, it is possible to make some observations about law reform in relation to the three problems identified in

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[127] *Inquest into the Death of June Woo* (Unreported, Queensland Coroner's Court, State Coroner Barnes SM, 1 June 2009).

this article that are specific to Queensland law.[128] In doing so, we stress that the focus of this article is on medical professionals' knowledge of the law. There may be (and we believe are) other aspects of Queensland law that require reform, but these are outside the scope of this article and this series.

The first, and most significant, problem with the law which is likely to have an impact on a medical professional's knowledge of the law is the requirement to obtain consent to withhold or withdraw futile treatment. There is an argument that obtaining consent may have some advantages. For example, it could be argued that this requirement provides an added protection of a vulnerable cohort, and decreases the possibility of life-sustaining treatment being withheld or withdrawn inappropriately. Further, a need to obtain consent ensures that a dialogue occurs between the treating team and the substitute decision-maker who is usually a family member or friend. However, legally enshrining such a requirement may not be necessary to fulfil this purpose. Medical professionals should, in any event, be informing the substitute decision-maker of the adult's condition, prognosis and recommended treatment. There are other compelling reasons not to impose a legal requirement to obtain consent to withhold or withdraw such treatment. An equivalent requirement does not exist at common law. It also does not represent the law in Queensland that applies to withholding and withdrawing futile treatment from adults who have capacity. It is illogical not to impose a consent requirement when a person possesses capacity, but to impose the obligation if the same person later loses capacity.

On balance, the authors suggest that the Queensland law should be reformed to remove the obligation of medical professionals to obtain consent to withholding or withdrawing futile treatment.

The second concerning feature of Queensland law that is likely to affect the ability of medical professionals to know the law, is the uncertain status of common law advance directives. For the reasons articulated in the article,[129] the authors are of the view that common law advance directives do not have legal effect following the enactment of guardianship legislation. This is likely to be confusing to medical professionals as such directives have legal force in most other jurisdictions. Advance directives are an important feature of medical practice. For example, a competent adult who knows his or her condition will deteriorate to the point that he or she loses capacity may give verbal treatment instructions to take effect at that stage. These instructions will not comply with the formality requirements of the legislation and, therefore, will not constitute a valid AHD. However, they would be regarded as a valid common law advance directive. If common law directives do not have legal effect in Queensland, the medical professional will need to obtain instructions instead from a substitute decision-maker. The position is further complicated in Queensland as the

[128] Section 4.1 above.
[129] Section 2.3.1 above.

legislation contains an express provision that preserves the common law recognition of instructions about health care.[130]

The authors are of the view that the Queensland law should be reformed so that this uncertainty is removed, and common law directives are expressly recognised as having legal effect. This would mean that the verbal instructions of the formerly competent adult in the above example would have legal effect, as medical professionals would expect to be the case. It would also mean that a directive that does not comply with the statutory requirements would also be binding. Clarifying the law in the manner suggested would have the additional advantage of ensuring treatment preferences that are expressed by a competent adult would prevail, thereby promoting his or her autonomy.[131]

The final point is that there are potentially two different capacity assessments that may be relevant, and with which a medical professional needs to be familiar and apply, when attesting to the capacity of an adult who completes an AHD. The relevant legal argument about whether one test or two tests apply was explored earlier in the article.[132] Such uncertainty will prevent a medical professional from knowing the correct legal test and, therefore, from applying it. The authors are of the view that the law should be reformed to clarify the position, and suggest that an adult must satisfy both capacity tests to be able to complete an AHD.

This concludes the review of the law that governs withholding and withdrawing life-sustaining treatment from adults who lack capacity, and medical professionals' knowledge of that law, in Queensland. We turn now to consider in the position in Victoria in the third and final article of this series.

Postscript

After submission of this article for publication, the final report of the Queensland Law Reform Commission was tabled in Parliament (12 November 2010): Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws,* Report No 67 (2010) Vol 1-4. Of particular relevance to the subject matter of this article are chapters 9 (Advance Health Directives) and 11 (The Withholding and Withdrawing of Life-Sustaining Measures).

[130] *Powers of Attorney Act 1998* (Qld) s 39.
[131] B White and L Willmott, 'Will You Do as I Ask?' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77, 87.
[132] See section 2.3.1 above.